

APPENDIX 12b

WIC MEDICAL REFERRAL FORM
FOR

☐ Pregnant Woman

☐ Breastfeeding Woman

PATIENT'S NAME _____

ADDRESS _____

PHONE _____ BIRTHDATE _____ AGE _____

The following information is required for referral to the WIC Program:

ALL WOMEN:	ALL WOMEN:	PREGNANT:	BREASTFEEDING:
Present wt: _____	Hct: _____ % and/or	E.D.C. _____	Del. date: _____
Present ht: _____	Hgb: _____ gm	Wks gest: _____	Gest. age: _____ wks.
Date taken: _____	Date taken: _____	Prepreg. wt.: _____ lbs.	Wt. gained: _____ lbs.
Vit/Min Rx: _____	_____	Wt. gained: _____ lbs.	Prepreg. wt.: _____ lbs.

Please check (✓) any medical/nutritional condition which might (or has) influenced the outcome of this pregnancy.

<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Chronic disease: _____
<input type="checkbox"/> Previous stillbirth, miscarriage, abortion	<input type="checkbox"/> Hypertension, diabetes
<input type="checkbox"/> Previous premature delivery	<input type="checkbox"/> Late entry to OB care (after 1st trimester)
<input type="checkbox"/> Multiple birth or fetus	<input type="checkbox"/> Substance abuse: _____
	<input type="checkbox"/> Therapeutic diet ordered: _____

Additional Diagnoses/Health Concerns: _____

Physician or Health Professional's Name _____

Address: _____

_____ Phone: _____

Medical Office/Clinic: _____

Signature: _____ Date: _____

Final eligibility is based on a combination of nutritional, financial and medical criteria which will be determined by the local WIC Project.

This is an Equal Opportunity Program. If you believe you have been discriminated against because of age, race, color, handicap, sex, creed, national origin, ancestry, sexual orientation, arrest or conviction record, marital status, or religion, write immediately to your local WIC project. If you are not satisfied or if you do not get a response in approximately 30 days, write to DHSS, Affirmative Action/Civil Rights Compliance Office, P.O. Box 7850, Madison, WI 53707.

LOCAL WIC PROJECT:

THANK YOU FOR YOUR COOPERATION